AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION to Valeriya Cotten, MA, LPC

Please fill this form out listing the primary care doctor or psychiatrist of client

Client's Name:_____

Sex ____ Age ____ DOB ___/___/___ SS#: _____-____-_____

I, _____,
Client's Name or Legal Guardian if client is a minor

authorize Valeriya Cotten, MA, LPC#4107 **[release] [request] [share]** *(circle all that apply)* any confidential information **[to] [from] [with]** *(circle all that apply),*

_____ _____.
Name of Provider/Therapist/PCP/Other Phone #

This release of information will be valid between the dates of ___/___/___ and ___/___/___ and will expire on ___/___/___.

Information to be shared may consist of: records or verbal consultations concerning treatment, diagnosis, information, assessment and/or education.

Specifically (please mark all that apply):
All Clinical Records ___
Psychological Evaluation ___
Educational Evaluation ___
Medical History ___
Social History ___
Discharge Summary ___
Psychiatric Evaluation ___
Mental Health Info ___
Drug/Alcohol tests & results ___
Other: _____

The information is needed for the purpose of adopting a more comprehensive and integrated approach to the therapy and maintaining a continuity of care for this purpose only unless otherwise permitted or required by law.

This authorization may be revoked at any time by the client. Revoking of this authorization shall not cancel any prior action that has already transpired.

If not revoked, it shall terminate the last day of the clinical treatment or on the expiration day listed, whichever comes first.

A photocopy, facsimile or duplicate copy of this authorization shall be as valid as the original.

The person signing this consent has a right to receive a copy of it.

I have read and understand the nature of this release. I understand that I may revoke it at any time. I release Valeriya Cotten, MA, LPC from any liability that may arise from this action whether or not foreseen at present.

_____ _____

Signature of Client or Legal Representative Date

_____ _____

Witness Signature Date

*PRIVACY ACT STATEMENT

1. The purpose for soliciting the information is to provide the therapist/counselor data to assist in counseling you are seeking.

3. The information will be maintained under strict professional guidelines and until, by law, your records are released to be destroyed.

4. Providing the information is voluntary. There will be no adverse effect on you for not furnishing the information other than that certain data might not otherwise be available to the counselor/therapist to enable him/her to provide you the most effective therapy.